

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

8371 2

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Bernie, Mo. R.R. 1  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Louis A. Williams

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security

No. 489-18-7306

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rosa Williams

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased May 7 1898  
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer - Laborer

11. Industry or business

MOTHER FATHER  
12. Name Andy Williams  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Mollie Nanny  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rosa Williams

(b) Address Bernie, Mo. R.R. 1

17. (a) \_\_\_\_\_ (b) Date thereof 2-7-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden, Mo.

18. (a) Signature of funeral director Ladness Funeral Home

(b) Address Danville, Mo.

19. (a) Feb 15-1940 (b) Laura Hopkins  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard  
(c) City or town Bernie  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5 year 1940 hour 7 minute p M.

21. I hereby certify that I attended the deceased from Jan 29, 1940 to Feb 5, 1940  
that I last saw him alive on Feb 5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration 5 days

Due to Trauma  
1-29-40 Fall

Due to and hitting  
downward crushed right

Other conditions side of chest  
(Include pregnancy within 5 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 1-29-40  
(c) Where did injury occur? Stoddard, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Out in woods along river  
While at work? Yes (Specify type of place) (e) Means of injury Fall

23. Signature E. Davis (M. D. or other) 1  
Address Bernie, Mo. Date signed 2-6-40

RECEIVED

District Health Officer No. 2,

District File Number 340-731

Date Filed 3/11/40

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**